

State Planning Grant Consultant Team

University of Washington Health Policy Analysis Program
Rutgers University Center for State Health Policy
RAND
William M. Mercer, Incorporated
The Foundation for Health Care Quality

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Financial Incentives to Employers to Offer Insurance

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This report was prepared by M. Susan Marquis, of RAND and Carolyn A. Watts, of the University
of Washington Health Policy Analysis Program.

This report was prepared by a consultant team comprising:

University of Washington Health Policy Analysis Program

Aaron Katz, Director and Co-Principal Investigator
Suzanne Swadener, Project Manager
Mark Gardner, Senior Policy Analyst
Jennifer Phipps, Policy Analyst
Judith Yarrow, Editor
Carolyn A. Watts, Professor and Faculty Associate
Robert Crittenden, Associate Professor, Department of Family Medicine
Peter House, Clinical Associate Professor, Department of Family Medicine
Larkin Strong, Research Assistant

Rutgers University Center for State Health Policy

Joel Cantor, Director and Co-Principal Investigator
Kimberley Fox, Senior Policy Analyst
Cara Cuite, Research Analyst

RAND

M. Susan Marquis, Senior Economist
Roald Euller, Associate Director of Research Programming

William M. Mercer, Incorporated

James Matthisen, Principal
Florence Katz, Senior Consultant
David Frazzini, Associate
Judy Miller, Consultant

Foundation for Health Care Quality/Community Health Information Technology Alliance (CHITA)

Elizabeth Ward, CHITA Director
Elizabeth Whitney-Teeple, Consultant

Health Policy Analysis Program
University of Washington School of Public Health and Community Medicine
1107 NE 45th St., Suite 400, Seattle, WA 98105
Phone 206-543-3670, Fax 206-543-9345, www.hpap.washington.edu

Center for State Health Policy
Rutgers, the State University of New Jersey
314 George St., Suite 400, New Brunswick, NJ 08901
Phone 732-932-3105, Fax 732-932-0069, www.cshp.rutgers.edu

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Financial Incentives to Employers to Offer Insurance

Executive Summary

Financial incentives to employers are intended to expand access to employer-sponsored coverage by inducing additional employers to offer coverage as a benefit. Policy options include:

- Reducing the price of coverage to employers through direct subsidies or tax credits
- Mandating that employers offer coverage or pay a tax to finance a public insurance program (“play” or “pay”)

Studies of employers’ demand for insurance and experiences of demonstration projects to subsidize employers suggest that even fairly substantial subsidies are unlikely to result in a very large increase in the number of employers that offer insurance; they would affect only about 11 percent of Washington’s uninsured population.

Mandating employer coverage may have larger effects on the uninsured, but employer mandates will not lead to universal coverage unless coupled with an individual mandate. A mandate to cover all workers and dependents would reach only about one-fourth of the uninsured population. Moreover, mandates may have unwanted employment effects, although evidence suggests these will be small. ERISA may also limit the use of strategies requiring that employers finance health benefits, such as play-or-pay mandates.

This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team.

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Problem Definition

Most private health insurance is provided through the workplace. Almost 50 percent of the uninsured have an employed family member.* However, not all workers and their families have access to insurance from employers. Policies to provide incentives to encourage more employers to offer insurance seek to reduce the number of uninsured by building on the employer-sponsored base. Examples of this approach include voluntary efforts that would provide subsidies to employers to encourage more of them to offer coverage and pay for part of its cost and mandates such as a play-or-pay law that requires firms to offer coverage or to pay a payroll tax toward coverage in a public program. Advocates of expanding the employment-based system point to its natural risk pools, administrative efficiencies, and employees' preference for obtaining insurance in this way (Feder, 2001). Incentives to employers are primarily designed to encourage more employers to offer coverage as a benefit. They could also, however, induce some employers who currently offer coverage to alter their contribution policy, which could have beneficial effects on employee participation.

Description of Design Options

A number of choices that must be made in designing voluntary or mandatory approaches to expand the availability of employer-sponsored coverage are summarized in Figure 1. The key issues are highlighted below.

Voluntary Subsidies

Eligibility. Proposals to subsidize employers who do not currently offer coverage often try to reach those individuals who can least afford insurance indirectly using characteristics of the employers—such as low-wage business or size of business (Meyer & Wicks, 2001). However, it is difficult to target employees using characteristics of their employers (Long & Marquis, 2001). A large share of low-wage workers, for example, work for businesses that would not be classified as low-wage firms. For example, 45 percent of low-wage workers are in businesses in which at least one-fourth of the workforce earn more than \$10 per hour.† And although small businesses are less likely to offer insurance than large businesses, large shares of both the uninsured and low-income workers are in larger businesses. For example, 35 percent of

* This does not count the one-third of the uninsured who are self-employed.

† Tabulations from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

uninsured workers and their dependents are in businesses with more than 50 workers, and 47 percent of low-wage workers are in these larger businesses.*

Employer subsidies that are based on characteristics of the workers also are likely to lead to segmentation of the workforce. For example, subsidies available only to firms that have a preponderance of low wage workers could lead low-wage workers to congregate in certain firms and high-wage workers to congregate in other businesses (Steuerle, 1994).

For budgetary reasons, programs to subsidize employers often require that there be some minimum period during which coverage is not offered prior to qualifying for the subsidy. The objective of such restrictions is to discourage employers from dropping current coverage arrangements to take advantage of the subsidy. However, such an approach penalizes firms that already offer coverage. It would provide a competitive advantage to those who take the subsidy by enabling them to provide employees a compensation package at lower cost than otherwise similar firms who offer insurance but are ineligible for the subsidy. Providing temporary subsidies to induce firms to offer insurance may overcome this objection, but temporary subsidies are likely to induce fewer employers to provide coverage than would permanent subsidies.

Typically, employers must contribute a specified share of the premium and provide a minimum benefit to qualify for a subsidy. For a given subsidy amount, the higher the required employer contribution and the more generous the required benefit, the lower the expected increase in offer rates. Economists generally believe that the incidence of the cost of employer-paid health insurance premiums is on wages; employees who receive part of their compensation in health insurance benefits receive lower cash wages than they would receive without the insurance benefit. If employer costs are shifted, employers should not care about the required contribution amount. However, in the short run employers may be unable to shift the full required contribution to workers; and thus higher employer contributions might create disincentives to provide coverage. On the other hand, lower employer contribution rates and less generous plans will be less attractive to employees, and employee take-up may be adversely affected. In addition, increases in access to care will be lower with plans that provide less generous benefits to patients.

Choices also must be made about the workers whose coverage qualifies for the subsidy. Requiring that employers make coverage available on the same basis to full- and part-time workers to qualify for the coverage would expand access to a group that often is excluded from employer plans. However, for a fixed subsidy per worker, the relative increase in the cost of employing part-time workers would be greater than the increase in the cost for full-time workers and could have negative employment consequences for the former group. Permitting employers to qualify part-time workers on a voluntary basis might be a solution.

Subsidy amount. The subsidy must be large enough to induce a significant proportion of employers who do not now offer coverage to do so. We review, below, the empirical literature on how employers respond to lower prices of insurance and the evidence from demonstrations of small subsidies. This evidence suggests that the subsidy will have to be set to cover a substantial share of the premium cost of the minimum-required plan. One recent analysis suggests that subsidies should be at least one-half of the cost (Meyer & Wicks, 2001). Large subsidies,

* Tabulations from the 2000 WSPS and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.

however, will encourage employers to drop offered insurance to take advantage of the subsidy, unless the eligibility criteria do not include provisions about previous periods of non-offering.

A fixed dollar subsidy provides incentives for employers to shop for the best value plan; on the other, hand it may also lead employers simply to purchase the least cost plan that would qualify without regard to value. This suggests that the minimum benefit plan must be adequate to yield desired levels of access. A fixed-dollar subsidy, however, discriminates against employers with higher risk employees, since the cost of a given plan will be greater for these groups.

Administration. Administration of the voluntary subsidy program could occur through one of several existing agencies, including the Health Care Authority (HCA), which through Basic Health (BH), already has a track record of working with employers to purchase BH coverage. An advantage of this approach is that while the state would need to create the rules, determine eligibility, and administer the subsidy, administrative costs associated with contracting and purchasing insurance falls to employers. However, these administrative costs reduce the attractiveness of the subsidy to employers.

Financing. Financing for the subsidy could come from state general revenues, a more specific state source (e.g., “sin” taxes), or from business taxes. The stability of the revenue source is critical because employers are less likely to undertake the effort and expense of creating a new benefit program if the subsidy is not likely to be available over time. Financing the subsidy of employer-sponsored insurance from business taxes penalizes businesses that already provide insurance as well as those who benefit from the subsidy.

Play-or-Pay Mandate

Eligibility. A play-or-pay mandate would require that employers offer coverage or pay a payroll tax to support a public program. However, to mitigate concerns about the viability of very small businesses and the employability of certain workers, some past mandate proposals have exempted some classes of employers and employees or proposed transitional subsidies. Such exemptions, of course, reduce the universality of this approach.

An issue related to eligibility that arises with employer mandates is how to treat dual-worker families and those with multiple jobs. Employer mandates are usually implemented per employer/per worker, requiring that employees be covered at their own place of business. This may impose high costs on those holding full-time jobs, who may effectively be required to pay for insurance twice, and for dual-worker families, who may be required to pay for the cost of two single policies rather than a family policy. Rebates for dual coverage and systems to account for coverage of dual workers could be implemented to overcome these problems, but add to administrative costs. Policies toward dual-worker families may also have distributional consequences for employers, especially in the short run. If the mandate allows dual workers to select one employer’s plan and the selected employer is unable to fully shift additional employer contributions to wages, the selected employer will bear adverse cost consequences relative to the unselected employer.

Setting the contribution and payroll tax. If the payroll tax per worker is less than the required employer contribution per worker, most employers would be expected to pay the tax and enroll their workers in the public plan. Thus, the smaller the payroll tax for a given contribution and minimum benefit plan, the larger will be the public plan. In addition, employers who pay will have employees for whom the insurance cost is greater than the tax cost. Consequently, the

payroll tax will not cover the cost of the public plan, and there will be some residual public cost to be covered by general revenues. This residual cost will also be greater the smaller the payroll tax, given the employer contribution requirement and the minimum benefit plan.

In the long run, a mandate that employers provide health insurance would be expected to result in lower wages to workers who do not currently receive employer coverage, if employers fully shift costs to wages. In the short run, however, employers may not be able to shift the costs of a mandate to workers—this is especially true for low-wage workers, since the minimum wage and the mandate may raise the cost of hiring these workers above the amount employers are willing to pay. In the short-run, then, some workers may experience adverse employment effect—either job losses or a shift to part-time (ineligible) work status. The greater the tax or the minimum contribution amount, the larger would be the employment effects. We will provide some evidence, below, on the magnitude of employment effects.

Administration. Although the administrative costs of creating and implementing a new benefit program will fall on employers who choose to “play,” the state must incur the costs of monitoring the mandate and administering the “pay” part of this approach. This would involve collecting the assessments on employers who choose not to offer insurance and enrolling their employees in an acceptable benefit plan. The latter two functions could be carried out by the Basic Health / Health Care Authority or perhaps in conjunction with the WSHIP. Existing state law would require that any administrative costs for nonsubsidized coverage through Basic Health would have to be covered by charging an administrative fee.

Financing. Employers who choose to “play” will finance coverage for their own workers. For those employers who choose to “pay,” their assessments will cover some part of the cost of coverage for their workers. The lower the assessment on employers, the larger the number of employers that will choose to “pay” rather than “play,” and the more residual funding will be needed from state revenues. The federal Employee Retirement Income Security Act (ERISA), enacted in 1974, preempts state laws that relate to employee benefit plans. Thus ERISA may limit the use of many strategies that states may wish to undertake to expand insurance coverage through the employment-based system. This includes strategies requiring that employers finance health benefits, such as play-or-pay mandates.

Evidence

In this section we review the quantitative and qualitative evidence on the likely effects of subsidies to employers. We begin with a discussion of the size of the target population in Washington. Then we review the literature on behavioral responses.

Potential Target Population

The population of uninsured people and of private businesses that are potentially affected by various employer incentive policies to reach the uninsured are shown in Figure 2. We consider subsidy schemes that are targeted to small businesses, low-wage businesses (defined as businesses with at least two-thirds of workers earning less than \$10 per hour), and all businesses. The first column of Figure 2 shows the percent of uninsured individuals who might benefit from the policy in question. For example, about 9.4 percent of the uninsured (percentage includes

dependents) are full-time workers in small businesses that do not currently offer insurance and so might benefit from subsidies to small businesses that add coverage for full-time workers. The second column shows the percent of uninsured employees and dependents that might benefit from the policy. For example, about 23 percent of uninsured people (percentage includes dependents) who are workers are employed full-time in small businesses that do not currently offer insurance and might benefit from policies aimed at increasing offer rates among small businesses. The last column shows the percent of private business establishments that might qualify for a subsidy. Our estimates of the potential target population for these schemes take into account only those in businesses that might be induced to offer coverage; it does not consider the effect that a subsidy scheme might have on eligibility rules or on employer contribution rates. For example, a subsidy to small businesses that offer coverage to full- and part-time workers with a minimum contribution rate of 70 percent might encourage some small businesses to modify their eligibility requirements or increase contribution rates. The estimates show the potential reach of these programs; they do not incorporate estimates of the number of employers who will actually participate or estimates of workers in these businesses who would enroll in coverage.

Estimates of the number of uninsured and the number of businesses affected by a play-or-pay mandate include the number of uninsured who are currently in businesses offering insurance but ineligible for coverage and businesses that would be required to expand their eligibility as well as businesses that do not offer coverage. The number of businesses and workers who would be affected by play-or-pay mandates depends on a number of critical design choices. Mandating that employees receive their insurance through their own employer would involve substantial changes in the source of coverage for many workers; almost one-fourth of workers in Washington state are currently covered by a spouse's employment-based policy.* Depending on the size of the required employer contribution to "play" and the payroll tax to "pay," this policy could lead a substantial number of employers that currently offer private coverage to drop the offer and contribute to the public program. In turn, this could have implications for the number of uninsured, depending on workers preferences for public versus private coverage and on whether the employer mandate is accompanied by an individual mandate.

Employer's Offer Response to Subsidy

Subsidies to employers are intended to lower the cost of offering insurance and encourage more employers to voluntarily offer insurance. Figure 3 presents estimates from the literature on the elasticity of firm offer rates to changes in the cost of coverage. The elasticity gives the percent change in the proportion of businesses offering coverage for a percent change in price. Thus, an elasticity of -.5 suggests that a 10 percent decrease in price would increase the proportion of business offering coverage by 5 percent. Estimates range from about -0.1 to -1.6. However, the largest estimate is based on employers' reported intentions when given hypothetical price reductions; estimates based on observed behavior range from -0.1 to -0.7. These estimates suggest that a subsidy to small businesses of 50 percent of the premium would increase the number of these businesses offering insurance by about 5 to 35 percent (i.e., 0.5×-0.1 to 0.5×-0.7). The number of workers offered insurance would increase by only about 1 to 4 percent because the vast majority of workers are in large businesses that currently offer coverage.

* Tabulations from the 1997 Washington State Study of the Uninsured.

The low response to subsidies is confirmed by experience in states that have employer subsidy programs. A disappointingly small number of businesses participated in demonstration projects carried out in the early 1990s to subsidize small businesses newly offering insurance (Helms, Gauthier & Campion, 1992; and McLaughlin & Zellers, 1992). Several states have subsidy programs in place, and they too report few participants (Silow-Carroll, Anthony, & Meyer, 2000). Kansas offers a tax credit for up to six years to business with 2 to 50 employees that newly offer coverage; enrollment in the program began in 1999, and as of mid-May 2000 only 62 companies were enrolled. In Massachusetts, small businesses with low-income employees are eligible to receive a subsidy for their low-income workers; about 800 employers and 1500 people are enrolled in the program. The New York State Health Insurance Partnership Program provides premium subsidies to small businesses that have not been providing insurance to workers. About 1100 businesses were enrolled in 1999; but the program will be phased out by mid-2003.

A number of studies have found that the characteristics of the workforce are important determinants of employers' decisions to offer insurance and, in particular, that employers with a large share of low-wage workers are less likely to offer coverage than other employers (Marquis & Long, 2001; and Gruber & Lettau, 2000). This suggests that low-wage workers may prefer cash benefits to insurance in the compensation package. A large number of employers not offering insurance also report lack of demand on the part of workers as a factor in the decision not to offer (McLaughlin & Zellers, 1992). Thus policies that enhance worker demand may be more effective in reducing the uninsured than policies targeted to employers.

Play-or-Pay Mandate

Effects on uninsured. Unless coupled with an individual mandate, a play-or-pay mandate would not necessarily result in universal coverage for workers and their dependents. That is, a play-or-pay mandate would require employers to offer coverage, but would not require employees to enroll in it. The expansion in insurance would be less the greater the required employee direct contribution. Expansion would also likely be less the lower the payroll tax. This occurs because the number of firms channeling workers to the public plan will be greater the lower the payroll tax; consequently the expansion in coverage would also depend on workers' preferences for private versus public coverage—about which we know very little. Because the cost of insurance is greater for small businesses than large businesses, the likelihood of being channeled to the public program would be greater for workers in small than in large businesses—the former are those employees least likely currently to have access to employer plans.

Effects on employment. A large number of studies have attempted to measure the extent to which health insurance costs are shifted to worker wages (Gruber, 2000). Despite mixed evidence, it is generally believed that in the long run these costs are fully shifted to wages. In the short run, however, full shifting may not be possible, especially for workers who are near the minimum wage. As a consequence, the cost of some labor may rise above the amounts employers are willing to pay, resulting in job loss or a shift to jobs that do not require insurance. Much of the debate about the proposed Clinton mandate, in fact, centered on the short-term employment effects of such a mandate. Based on employment effects stemming from changes in the minimum wage, Klerman and Goldman estimated that an employer mandate would result in a loss of only about 0.1 percent of jobs, though the loss rate for jobs held by teen-agers could be 1 to 2 percent (Klerman & Goldman, 1994; and Klerman, 1992). This estimate, however, was predicated on the assumption that firms are successful in passing on their share of the health

insurance premium, except as constrained by minimum wage laws. However, if nominal wages cannot be lowered and the shifting can occur only through the erosion of real wages, then the dislocations may be substantially greater.

The inability to fully shift costs may also lead to an increase of hours worked for some employers and a decrease for others. Employers may try to save on costs by substituting part-time jobs that do not require insurance for full-time jobs. They may also increase work hours for some employees, for example through overtime, and use fewer employees. Some evidence that increased costs of insurance produce this latter effect was reported by Cutler and Madrian (1998).

Redistribution. Mandates will typically redistribute income from lower-income to higher-income persons. This is because low-income workers would now pay for health insurance in the form of lower wages instead of receiving charity or publicly subsidized health care. Unless combined with subsidies or other mechanisms, then, mandates are likely to be regressive (Steuerle, 1994).

Washington State Context and History

Washington has some experience with both the voluntary subsidy approach and the mandated coverage approach to increasing employer-sponsored insurance.

Voluntary subsidies. An employer program was incorporated into Basic Health (BH) as part of the comprehensive health care reform legislation of 1993. The intent was to allow employers to buy Basic Health coverage for their employees. Premiums are subsidized for those employees who are determined by Basic Health to be within income guidelines, and employers are required to pay a minimum contribution toward the cost of the coverage. Employers send completed applications and documents for the group to BH, which determines the subsidy level (if any) for employees. Enrollment was slow. BH bills employers for the full payment for the group. The employer is required to contribute at least \$45 per month to the cost for each full-time participating employee and \$25 for each part-time employee, but may collect the balance of the premium from employees through a payroll deduction.

In 1995, the Washington Legislature established an overall BH enrollment target of 200,000, with budget appropriations assuming that employer-sponsored (nonsubsidized) enrollment would be half of that (100,000). By 1996, however, employer enrollment had only reached 2,000. Legislation in 1995 allowed the payment of commissions to agents and brokers to sell BH coverage, which assisted enrollment for about a year. However, no funding was authorized for this purpose in 1997, so no further commission payments were available. In 1999, premiums for the nonsubsidized program increased 61 percent, and nonsubsidized enrollment (both individual and employer-sponsored) fell dramatically. Plan participation for the nonsubsidized program began to destabilize in 2000, and many plans refused to offer the nonsubsidized program. To protect the subsidized program, the agency eliminated the requirement that plans offer both programs. By 2001, nonsubsidized coverage was quite limited. One plan offered coverage in five counties, three more plans agreed to continue coverage for existing nonsubsidized enrollees, but would not take new nonsubsidized enrollees.

Mandates. An employer mandate was part of the health care reform legislation, the Health Services Act, passed by the Washington Legislature in 1993. However, before it could be implemented, the mandate was repealed by HB 1046 in 1995.

Implications

The experience with and research concerning incentives for employers to offer coverage suggest the following key points:

- Subsidies are unlikely to induce many more firms to offer health insurance voluntarily unless coupled with policies to enhance employee demand.
- It is difficult to target the neediest population through employers, so the cost of employer subsidies may be large. That is, not all low-income workers are in primarily low-wage businesses, and not all workers in primarily low-wage businesses have low incomes.
- Employer mandates will not lead to universal coverage, unless coupled with an individual mandate.
- Employer mandates will be regressive unless coupled with subsidies to low-income workers.
- Employer mandates may have small, unwanted employment effects in the short run.
- ERISA may limit the use of mandate strategies.

References

- Buchanan, J.L. & Marquis, M.S. (1999). Who gains and who loses with community rating for small business. *Inquiry*, Vol. 36, p. 30-43.
- Cutler, D. & Madrian, B. (1998). Labor market responses to rising health insurance costs: evidence on hours worked. *RAND Journal of Economics*, Vol. 39 (3), p. 509-530.
- Feder, J. Levitt, L., O'Brien E., & Rowland, D. (2001). Assessing the combination of public programs and tax credits. In J.A. Meyer & E.K. Wicks (Eds.), *Covering America, Real Remedies for the Uninsured*. Washington, DC: Economic and Social Research Institute.
- Gruber, J. (2000). Health insurance and the labor market. In J.P. Newhouse & A.J. Culyer, (Eds.) *Handbook of Health Economics* (pp. 646-706) Amsterdam, North Holland: Elsevier.
- Gruber, J. & Lettau, M. (2000). How elastic is the firm's demand for health insurance? NBER Working Paper Number 8021, Cambridge, MA: National Bureau of Economic Research.
- Helms, W.D., Gauthier, A.K., & Campion, D.M. (1992). Mending the flaws in the small-group market. *Health Affairs*, Vol. 11, 2, p. 7-27
- Klerman, J.A. (1992). Employment effect of mandated health benefits. In *Health Benefits and the Workforce* (p. 145-168). Washington, DC: Department of Labor.
- Klerman, J.A., & Goldman, D.P. (August 17, 1994). Job loss due to health insurance mandates. *Journal of the American Medical Association*, Vol. 272, p. 552-566.
- Long, S.H., & Marquis, M.S. (2001). Low-wage workers and health insurance coverage: Can policymakers target them through their employers? *Inquiry*, Vol. 38, p. 331-337.
- Marquis, M.S., & Long, S.H. (2001). To offer or not to offer: the role of price in employers' health insurance decisions. *Health Services Research*, Vol. 36, p. 935-958
- McLaughlin, D.G. & Zellers, W.K. (1992). The shortcomings of voluntarism in the small-group insurance market. *Health Affairs*, Vol. 11 (2), p. 28-40.
- Meyer, J.A. & Wicks, E.K. (2001). A federal tax credit to encourage employers to offer health coverage. *Inquiry*, Vol. 38, p. 202-213.
- Silow-Carroll, S., Anthony, S.E., & Meyer, J.A. (2000). *State and local initiatives to enhance health coverage for the working uninsured*. New York, NY: Commonwealth Fund.
- Steuerle, C.E. (1994). Implementing individual and employer mandates. *Health Affairs*, Vol. 13, p. 54-68.
- Thorpe, K.E., Hendricks, A., Garnick, D., Donelan, K., & Newhouse, J.P. (1992). Reducing the number of uninsured by subsidizing employment-based health insurance: Results from a pilot study. *Journal of the American Medical Association*, Vol. 267, p. 945-48.

Appendix

Figure 1. Incentives to Employers to Offer Insurance: Design Choices

Figure 2. Potential Target Populations for Employer Incentive Policies

Figure 3. Elasticities of Employer Offer Rate and Subsidy to Small Businesses

Figure 1. Incentives to Employers to Offer Insurance: Design Choices

Design Choice	Options and Issues	
	Voluntary Subsidies	Play-or-Pay Mandates
Who is eligible	Restrictions to low-wage or small businesses	Exemptions to micro-business; seasonal businesses; part-time employees
	<i>Advantages:</i> Emphasizes expansion of access to those who can least afford it	<i>Advantages:</i> Minimize negative employment consequences
	<i>Disadvantages:</i> Many low-wage workers are in other businesses; promotes segmentation of workforce	<i>Disadvantages:</i> Reduces decrease in uninsured
	Required period since last offered coverage	Which employees are covered
	<i>Advantages:</i> Target the uninsured; minimize adverse behavioral consequences; minimize budgetary cost	Part time workers
	<i>Disadvantages:</i> unequal treatment of equals; enforcement costs	<i>Advantages:</i> Expanded access to coverage
		<i>Disadvantages:</i> Adverse employment effects
	High minimum required employer contribution	Workers at own place of business
	<i>Advantages:</i> Increase in take-up by employees	<i>Advantages:</i> Administrative simplicity
	<i>Disadvantages:</i> May deter employer participation	<i>Disadvantages:</i> Dual-worker families: may prefer common plan redistribution of costs among employers of dual workers; higher cost to dual-worker families
The amount	Coverage of part time workers	
	<i>Advantages:</i> Expanded access to coverage	
	<i>Disadvantages:</i> Adverse employment effects	
	Subsidy amount	Minimum employer contribution to play vs. payroll tax
	Substantial subsidy necessary for participation	Size of public plan greater the lower tax vs. contribution
	Size of subsidy may affect decision to drop coverage (if eligibility requires period of not offering)	Public costs greater the lower the tax vs. contribution
		Employment effects greater the higher the tax and the contribution
	Fixed dollar vs. proportional to cost	
	Incentive to shop vs. incentive to underinsure	
	Favors low vs. higher risk groups	
	Minimum benefit that can be purchased	Minimum benefit that must be purchased
	Participation vs. improvements in access to care	Size of public plan vs. improvements in access to care
Administration	Form of subsidy: tax credits vs. direct payment	Treatment of dual worker families; multiple jobs
	Administrative mechanism exists with tax credit, but business liquidity issues Direct payment may help cash flow issues, but reporting requirements may be costly.	Most employer mandates are per employer/per worker; raises cost of insurance to dual-worker families and those with multiple jobs relative to others
Financing		Sources of residual financing of public plan
	Sin taxes; taxes on providers/plans.	Sin taxes; taxes on providers/plans

Figure 2. Potential Target Populations for Employer Incentive Policies

Policy	% of Uninsured Population	% of Uninsured Workers & Dependents	% of Private Business Establishments
Subsidy(a)			
To small businesses adding offer (b)			
To full-time workers (c)	9.4	23.2	49.4
To all workers	11.3	27.9	49.4
To low-wage businesses adding offer (d)			
To full-time workers (c)	2.7	6.7	28.8
To all workers	3.6	8.9	28.8
To all businesses adding offer			
To full-time workers (c)	11.5	28.4	52.1
To all workers	13.5	33.3	52.1
Play-or-pay mandate (e)			
To offer full-time workers (b)	15.0	37.0	52.1
To offer all workers	23.1	57.0	85.4

(a) We do not account for indirect effects that the availability of a subsidy might have on employer contribution rates and eligibility rules in firms offering insurance; estimates are for those in businesses that do not offer.

(b) Business with 50 or fewer employees

(c) 35 hours or more

(d) Businesses with at least two-thirds of workers earning less \$10 per hour.

(e) Would affect persons in offering firms who are not eligible under current arrangements as well as those in businesses not offering. We do not account for the effect that mandates to obtain coverage through own employer would have nor the effect of contribution rules specified by the mandate.

Source: 2000 WSPS and 1997 The Robert Wood Johnson Foundation Employer Health Insurance Survey

Figure 3. Elasticities of Employer Offer Rate and Subsidy to Small Businesses

		Base rate		50% subsidy	
	Elasticity	Small businesses offering	Employees offered	Small businesses offering insurance	Employees offered
Marquis and Long, 2000	-0.14	39.4	83.4	42.1	84.1
State experiments	-0.1 to -0.7	39.4	83.4	41.4 - 53.2	83.6 - 86.8
Gruber & Lettau, 2000	-0.3	39.4	83.4	45.3	84.9
Buchanan & Marquis, 1999 (b)	-0.3	39.4	83.4	45.3	84.9
Thorpe et al. 1992 (b).	-1.6	39.4	83.4	70.9	91.2

(a) 50 or fewer employees

(b) Based on responses to hypothetical price variation